SHELBY COUNTY GOVERNMENT

NOTICE TO HEALTH PLAN PARTICIPANTS

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Shelby County Government has elected to exempt the Shelby County Government Healthcare Plan from all of the following requirements:

1. Limitations on preexisting condition exclusion periods. A preexisting condition exclusion period generally may not exceed 12 months, and generally must be reduced by the individual's prior health coverage. Also, a plan may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, nor, under certain conditions, with respect to newborns or children adopted or placed for adoption.

2. Special enrollment periods. Group health plans are required to provide special enrollment periods for individuals who do not enroll in the plan because they have other coverage, but subsequently lose that coverage, Also, if a plan provides dependent coverage, the plan must provide a special enrollment period for new dependents (and the employee if not already enrolled) within 30 days after a marriage, birth, adoption or placement for adoption.

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

4. Standards relating to benefits for mothers and newborns. Group health plans offering health coverage for hospital stays in connection with the birth of a child generally may not restrict benefits for the stay to less than 48 hours for a vaginal delivery, 96 hours for a cesarean section.

5. Required coverage for reconstructive surgery following mastectomies. Group health plans that provide medical and surgical benefits for a mastectomy must provide certain benefits in connection with breast reconstruction as well as certain other related benefits.

6. Coverage of dependent students on medically necessary leave of absence. Group health plans are required to continue coverage for up to one year for a dependent child, covered as a dependent under the plan based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

7. Parity in the financial requirements, cost sharing requirements, and treatment limitations applicable to mental health or substance use disorder benefits. Group health plans that provide both medical and surgical benefits and mental health or substance use disorder benefits are required to ensure that (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. Also, there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

8. Special enrollment periods under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009. Group health plans must permit employees and dependents who are eligible but not enrolled for coverage to enroll if (i) the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or (ii) the employee or dependent becomes eligible for a subsidy under Medicaid or CHIP.

The exemption from these federal requirements will be in effect for the 2012 Plan Year beginning January 1, 2012 and ending December 31, 2012. The election may be renewed for subsequent plan years. Under HIPAA, Shelby County Government is required to give enrollees notice of this exemption on an annual basis.

Please be advised that even though Shelby County Government has opted out of the above requirements, there have been no changes to the healthcare plans other than those mandated for grandfathered plans under the Patient Protection and Affordable Care Act.

HIPAA also requires the Plan to provide covered employees and dependents with a "Certificate of Creditable Coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan. If you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion should you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Should you have any questions about this Notice, please contact:

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